THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
ANNUAL
HEALTH BENEFITS PLAN MEMBERS' BILL OF RIGHTS REPORT

OCTOBER 1, 2001- SEPTEMBER 30, 2002

ANTHONY A. WILLIAMS
MAYOR

JAMES A. BUFORD
DIRECTOR

THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH
ANNUAL HEALTH BENEFITS PLAN
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DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
825 NORTH CAPITOL STREET, N.E., SUITE 4122
WASHINGTON, D.C. 20002

REPORT PREPARERS
PATRICK E. KELLY, AIE
GRIEVANCE AND APPEALS COORDINATOR
Email Address: **Patrick2.Kelly@dc.gov**

LOVIE O. DAVIS, B.A.
STAFF ASSISTANT
Email Address: **Lovie.Davis@dc.gov**

TELEPHONE: (202) 442-5977
FAX: (202) 442-4797

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I. EXECUTIVE SUMMARY

The Health Benefit Plan Member's Bill of Rights law passed by the D.C. Council in 1998, as codified at D.C. Official Code § 44-301 et *seq.*, established a procedure for members to appeal adverse decisions by their health benefit plan and insurers, which deny, limit, or terminate a covered medical service on the grounds that it is not medically necessary.

The law requires: 1) health benefit plans and insurers to send a written notice of the adverse decision to the member and the member's healthcare provider within five (5) business days of the denial; 2) the written notice to inform the member of internal grievance and external appeal processes; and 3) the member to file an external appeal with the Director of the Department of Health (DOH) or his designee, the Grievance and Appeal Coordinator, within thirty (30) business days after receipt of an adverse decision letter from the insurer.

Furthermore, the law requires: 1) the Director to contract independent review organizations (IROs) to review appeals and 2) all insurers to report their number of adverse decisions to the Director.

The law requires that an annual report be compiled that summarizes the data reported to the Director by health benefit plans.

II. DISTRICT OF COLUMBIA'S GRIEVANCE AND APPEALS LAW

The review process is divided into two parts: a) the internal review, which is conducted by the insurer; and b) the external review, which is conducted by DOH.

A. Internal Review: Insurer's Internal Grievance Process

If an insurer denies services based upon the lack of medical necessity, the insurer must provide the member with a written adverse decision within five (5) business days of its decision. The written adverse decision must include the following:

- A clearly stated decision;
- A detailed, comprehensible contractual or medical reason explaining the insurer's decision;
- An explanation of the insurer's internal grievance process;
- Notice that DOH can facilitate an external appeals process if the member is dissatisfied with the insurer's grievance decision;
- Notice that members have thirty (30) days from the date of the final adverse decision to file an appeal with the Director;
- The address, telephone number, and facsimile number of the Director's designee.

1. Requirements of Insurers

D.C. Official Code § 44-301.10 et *seq.* requires insurers to submit annual reports, which chronicles all activity during the preceding year. The report must include the following:

- The name and location of the reporting insurer;
- The reporting period in question;
- The names of the individual's responsible for the operation of the insurer's grievance system;
- The total number of grievances received by the insurer, categorized by cause, insurance status, and disposition;
- The total number of grievances for expedited review, categorized by cause, length of time for resolution, and disposition; and
- The total number of appeals for external review, categorized by cause, length of time for resolution, and disposition.

B. External Review: Appeals Process of DOH

If a member is dissatisfied with the insurer's grievance decision related to the determination of the medical necessity of their claim, the member may file an appeal at the following address: ***District of Columbia Department of Health, Office of the General Counsel, Attn: Grievance and Appeals Coordinator, 825 North Capitol Street, N.E., 4th Floor, Washington, D.C., 20002***.

Once a member files an appeal with DOH and all relevant information is received, the Grievance and Appeal Coordinator reviews the case to determine if it should be referred to an IRO for medical review. IROs are separate entities that DOH contracts to review appeal cases. They are comprised of certified medical professionals and physicians who specialize in the issue under review. IROs assess appeal cases on the basis of medical records, practice guidelines, and applicable clinical protocols. There is no cost to the member for an independent review. Under normal circumstances, an IRO must render a decision within thirty (30) days after receiving relevant documents. However, IROs must review emergency appeals within seventy-two (72) hours.

1. Additional Appeal Filing Locations

If members have concerns regarding the quality of services rendered by a physician, they may file a complaint at the following address: ***District of Columbia Department of Health, Health Regulatory Administration, 825 North Capitol Street, N. E., 2nd Floor, Washington, D.C., 20002. The telephone number is (202) 442-5888.***

Also, if members have concerns about services covered in their insurer's contract, they may file a complaint at the following address: ***Commissioner of the Department of Insurance and Securities Regulation, 801 First Street, N. E., 7th Floor, Washington, D.C., 20002. The telephone number is (202) 727-8000.***

III. CERTIFICATION OF INDEPENDENT REVIEW ORGANIZATIONS

Upon the certification of an IRO, the Director enforces standards to ensure independent review organizations do the following: (1) review appeals in strict confidentiality; (2) use qualified professionals and medical reviewers; and (3) demonstrate an ability to render decisions in an equitable and timely manner.

IROs may not be a subsidiary or in any way owned or controlled by a health benefit plan, insurer, or trade association of health care providers. Also, the IRO should not have any material, professional, familial, or financial conflict of interest with the following: (1) insurer; (2) any officer, director, or management employee of the insurer; (3) the physician, physician's medical group, independent practice associates, or the provider proposing the service or treatment; (4) the institution at which the service or treatment should be provided; or (5) the development or manufacture of the principal drug, device, procedure, or other therapy proposed for the member whose treatment is under review.

The Director of DOH has the discretion to deny an appeal assignment to a particular IRO if it yields a conflict or appearance of impropriety. Also, neither the IRO nor an individual working for an external review panel can be held liable for any recommendation presented by the independent review organization, except in cases of gross negligence, recklessness, or intentional misconduct.

IV. STATISTICAL DATA BASED ON APPEALS FILED WITH DOH

During the October 1, 2001 to September 30, 2002 reporting period, DOH's Grievance and Appeal Coordinator received a total of sixty (60) external appeals. The IROs reviewed thirteen (13) appeals asserting a denial of coverage based upon the lack of medical necessity. Members withdrew two (2) appeals because they were filed before the health benefit plan had reached its final decision in the internal grievance process. Thirteen (13) appeals were rejected because they did not involve medically necessary services. Thirteen (13) appeals were referred to the Department of Insurance and Securities Regulations because they involved coverage or contract interpretation issues. Fifteen (15) appeals were administratively dismissed. Appeals are usually administratively dismissed due to lack of sufficient information, i.e. a letter requesting a member to sign the authorization for the release of medical records or additional information was not responded to within a specified time frame. Finally, the health benefit plans reversed four (4) of their adverse decisions due to the receipt of additional information, which the member did not provide the health benefit plan during the internal grievance process.

V. CONSUMER OUTREACH

The success of the Program depends heavily on consumer outreach. In FY 2002, there were approximately nineteen hundred (1,900) requests for assistance from consumers and providers. The requests for assistance included correspondence, telephone, and facsimile inquiries requesting information about the Program, assistance with completing necessary forms, and explanations of both the insurer's internal grievance and DOH's external appeals processes.

Secondly, despite the explanations, many consumers continuously express confusion and frustration about exhausting the internal grievance and external appeal processes. In fact, such feelings have led several consumers to forgo the processes. Consumers indicate distrust in receiving fair grievance and appeal decisions and cite that their health benefit plan is unresponsive at times.

Thirdly, research explains the low volume of appeals DOH received during the October 1, 2001 to September 30, 2002 reporting period can be attributed to the lack of consumer awareness and/or the members' burden of illness. Moreover, in states where consumer outreach increased, the number of appeals also increased significantly.

Lastly, in the effort to address the aforementioned issues, DOH exhausts various consumer outreach efforts. DOH has done the following: 1) appeared at community meetings, legal seminars, and health programs sponsored by non-profit corporations; 2) developed an informational brochure and distributed it to various health care providers; and 3) created a web site that details information about the Program, including a) an appeal form and b) an authorization for the release of medical records form.

VI. FINANCING

The health benefit plans fund the operations of the Program. The Mayor is required to assess all health insurers to cover the costs of administering the program. The Department of Insurance and Securities Regulations, via a Memorandum of Agreement with DOH, performs an annual assessment of insurers.

VII. CONCLUSION

Overall, in FY 2002, the Health Benefits Plan Members' Bill of Rights program was successful. The program processed one hundred percent (100%) of the appeals received and provided a greater amount of assistance to members than in previous years, while ensuring that each member received a full and fair review of their appeal.

Appeals accepted by the Director in 2002 fell into five (5) categories: (1) Inpatient Hospital Stays (3 appeals); (2) Physicians Services (1 appeal); (3) Pharmacy Services (1 appeal); (4) Physical Therapy (PT), Occupational Therapy (OT) and Speech Therapy (ST) services including

Inpatient Rehabilitation Services (5 appeals); (4) Durable Medical Equipment Services (2 appeals), and Home Health Services (1 appeal).

The range of services determined to be covered by the Director after being denied by the insurer were:

- Colonoscopy based on Health Benefits Plan's colorectal cancer screening guidelines;

- Speech Therapy based on Health Benefits Plan's contract criteria;

- Pharmaceutical Services based on Health Benefits Plan's medical criteria;

- Speech Therapy Services based on medical necessity;

- Habiliative Speech Therapy based on a non covered benefit;

- Home Health Services (24 hours) based on not medically necessary and service considered to be custodial care which was a policy exclusion; and,

- Durable Medical Equipment (Dynamic Cranial Orthoplasty (DOC) band based on Health Benefits Plan's medical policy that it is experimental and investigative and does not meet its technology evaluation criteria.

The Plans also reported the number of internal grievances, which they overturned (See Tab. B). The combined data shows that in 2002, forty-six percent (46%) of the internal adverse decisions were upheld, fifty percent (50%) were reversed with four percent (4%) being modified.

Based on the reports submitted it is clear that the law has had a positive effect on the ability of consumers to obtain medically necessary services. The Insurer's annual grievance reports are set forth in the attached Appendix.

VIII. RECOMMENDATIONS

Even though the program is reasonably successful there are measures which should be enacted to ensure that the health consumer's rights are fully protected. Therefore, in accordance with D.C. Official Code Sec. 44-301.10 (d), the following recommendations are made:

(1) Determinations of the Independent Review Organizations should be binding on both parties or at a minimum the health benefit plan. Under current law the determinations are not binding. Therefore, if the health benefits plan decides not to abide by the determination of the independent review organization, the member would then have the expenses and time associated with seeking a remedy through the courts.

(2) The Director should have regulatory authority under the law. The Director should have the authority to levy fines when a health benefits plan fails to follow the law, regulations or its internal grievance procedures.

(3) The definition section of the law should be reviewed to ensure that they are consistent with current practice definitions. (Example: “Health Insurer”, use HIPAA’s definition to ensure no impact on self insured plans under ERISA)

(4) The law should be amended to clarify that only grievances involving medical necessity are to be appealed to the Director, Department of Health. All other grievances or complaints concerning fair trade practices, rate increases, contract interpretations and non-payment of claims for reasons other than medical necessity should appeal to the Department of Insurance and Securities Regulation.

SUMMARY OF APPEALS REVIEWED BY INDEPENDENT REVIEW ORGANIZATIONS
LISTED BY INSURER
OCTOBER 2001- SEPTEMBER 2002

Insurer	Total	Insurer Upheld by IRO	Insurer Reversed by IRO	Insurer Modified by IRO
UniCare	2	1	1	0
CareFirst	6	2	4	0
Kaiser Permanente	2	0	2	0
Aetna Health	1	1	0	0
MAMSI	1	1	0	0
Monumental Life	1	1	0	0
Total	**13**	**6**	**7**	**0**

APPEALS BY JURISDICTION
OCTOBER 2001-SEPTEMBER 2002

DC	MD	VA	*OTHER	TOTAL
18	23	15	4	60

*** AZ, GA, NY, OR**

INDEPENDENT REVIEW BY JURISDICTION

DC	MD	VA	OTHER	TOTAL
4	5	4	0	13

SUMMARY OF APPEALS REJECTED BY DIRECTOR
(BY INSURER)
OCTOBER 2001 – SEPTEMBER 2002

INSURER	TOTAL
CareFirst BlueCross BlueShield	8
Capital Care	1
MAMSI	2
MAMSI (Optimum Choice)	1
Kaiser Permanente	2
TOTAL	14

SUMMARY OF APPEALS REJECTED/REFERRED BY DIRECTOR
(BY INSURER)
OCTOBER 2001-SEPTEMBER 2002

INSURER	TOTAL
Kaiser Permanente	3
CareFirst BlueCross BlueShield	9
MAMSI	2
TOTAL	14

TOTAL APPEALS FILED
OCTOBER 2001- SEPTEMBER 2002

APPEALS FILED	**60**
Referred to Department of Insurance and Securities Regulation	14
Referred to Other	0

ADVERSE DECISION	
Insurer Upheld by Independent Review Organization	6
Insurer Reversed by Independent Review Organization	7
Insurer Modified by Independent Organization	0
Insurer Reversed Itself After Appeal Filed	3
Referred File to Member to Exhaust Internal Appeal Process	0
Appeal Withdrawn	2
Appeal Rejected	11
Appeal Administratively Dismissed	17

SUMMARY OF APPEALS REFERRED TO INDEPENDENT REVIEW ORGANIZATIONS (LISTED BY SERVICE) 2002

Type of Service	Total	Insurer Upheld (DOH)	Insurer Reversed (DOH)	Appeal Rejected (DOH)
Inpatient Hospital Services	3	1	2	0
Emergency Room Services	0	0	0	0
Mental Health Services	0	0	0	0
Physicians' Services	1	1	0	0
Laboratory and Radiology Services	0	0	0	0
Pharmacy Services	1	0	1	0
PT, OT, and ST Services including Inpatient Rehabilitation Services	5	3	2	0
Skilled Nursing Services	0	0	0	0
Durable Medical Equipment Services	2	1	1	0
Podiatry Services	0	0	0	0
Dental Services	0	0	0	0
Optometry Services	0	0	0	0
Chiropractic Services	0	0	0	0
Home Health Services	1	0	1	0
Other	0	0	0	0
Total	**13**	**6**	**7**	**0**

SUMMARY GRIEVANCE DATA SUBMITTED BY INSURER*
(2002)

INSURER'S NAME	CASES REPORTED BY INSURER	ADVERSE DECISIONS UPHELD	ADVERSE DECISIONS OVERTURNED	ADVERSE DECISIONS MODIFIED
Aetna Health Inc.	15	7 (47%)	7 (47%)	1 (6%)
Allianz Life Insurance Co. of North America	0	0	0	0
AmeriGroup, District of Columbia	1	1 (1%)	0	0
Ameritas Life Insurance Co.	0	0	0	0
CareFirst Group Hospital & Medical Services	195	98 (50%)	90 (46%)	7 (4%)
CareFirst BlueChoice	43	13 (30%)	26 (61%)	4 (9%)
Capital Community Health Plan	0	0	0	0
CIGNA Healthcare Mid Atlantic Inc.	12	7 (58%)	5 (42%)	0
Clarendon National Insurance Co.	0	0	0	0
Connecticut General Life Insurance Co.	32	17 (53%)	15 (47%)	0
GE Financial Employer Services Group	2	1 (50%)	1 (50%)	0
George Washington Health Plan	0	0	0	0
Golden Rule Insurance Company	0	0	0	0

Guardian Life Insurance Company of America	11	7 (64%)	4 (36%)	0
Health Rite Inc.	0	0	0	0
Kaiser Permanente	180	71 (39%)	109 (69%)	0
MAMSI	62	39 (63%)	20 (32%)	3 (5%)
MD-Individual Practice Association Inc.	25	8 (32%)	16 (64%)	1 (4%)
Mutual of Omaha	0	0	0	0
Optimum Choice	184	83 (45%)	98 (53%)	3 (2%)
Pacific Life & Annuity Company	1	0	1 (100%)	0
Principal Financial Group	1	1 (100%)	0	0
Reliance Standard Life Insurance Co.	0	0	0	0
Trustmark Insurance Co.	0	0	0	0
UniCare	11	6 (54%)	3 (27%)	2 (19%)
United of Omaha Life Insurance Co.	5	3 (60%)	2 (40%)	0
Total	780	362 (46%)	397 (50%)	21 (4%)

* Individual Insurer Reports Attached